Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

HEALTH DATA ENTRY FORM
PART I

Reporter ID: _____
Student No.: _____
Grade: _____
Year 19: _____

Child's Name _____ Nickname _____ Date of Birth _____ Sex M or F

Legal Parents' Name: _____

Are parents Spanish speaking only? Yes or No _____

Is Either Parent Usually Home During the Day? _____

Current Address: _____ Telephone: _____

Directions: _____

Home Base Address: _____

Migrant Status: 1 2 3 4 Year in which last moved for agricultural work: 19: _____

Child's Regular Doctor: _____ Dentist: _____

Medicaid? Yes: _____ No: _____

Did this Child Attend School in Montana Last Year? Yes: _____ No: _____

If Yes, Name of School: _____

Health History: Describe positive responses on the blank lines below; include name/address of doctor or clinic which can be contacted for further information.

YES/NO

(1)_____ V12.06 Has this child had tuberculosis or ever had a skin test for tuberculosis? ¿Ha tenido este nino/a tuberculosis, o una reaccion positiva a la prueba de la piel para tuberculosis?

(2)_____ V12.4 Has he/she ever had any problems with his/her vision or with his/her hearing? ¿Ha tenido problemas de ver u oir bien? If yes, determine if uses or is supposed to use glasses (anteojos) or hearing aid (audifono/aparato de oido).

(3)_____ V12.41 Has he/she ever had epilepsy or ever had a convulsion or seizure? ¿Ha tenido epilepsia, ha tenido una convulsion o ataque?

(4)_____ V12.5 Has he/she ever had any kind of heart problem? Has he/she ever had a heart murmur? ¿Ha tenido problema con el corazon ¿Ha tenido un murmullo o soplo del corazon?

(5)_____ V12.51 Has he/she ever had rheumatic fever? ¿Ha tenido fiebre reumatica? (This must be a physician's diagnosis.)

(6)_____ V14 Is this child allergic to any kind of medicine (including over-the-counter medicine)? Has he/she ever had a serious reaction, that is, worse than mild fever or achiness, after getting any immunizations ¿Es alergico/a a alguna medicina? ¿Ha tenido una reaccion seria despues de recibir alguna vacuna, es decir mas seria que tener un poco de fiebre o sent irse poco adolorido?

(7)_____ V15.0 Does this child have any allergies to food, plants or animals? Does he/she have hay fever or asthma? ¿Ha tenido fiebre del heno o asma?

(8)_____ Has this child or anyone else in your family ever had hepatitis? (Must be doctor's diagnosis.) ¿Ha tenido este nino/a o alguien en su familiala hepatitis?

(9)_____ Is this child taking any medicines now, including medicines you can buy without a prescription? ¿Esta tomando este nino/a a guna medicina ahora, inclusive medicinas que se pueden comprar sin una receta?

(10)_____ Has this child ever had any operations or been in the hospital for any reason? ¿Ha tenido algunas operaciones, o ha estado en el hospital por alguna razon?

(11)_____ Has he/she had any serious illnesses or serious injuries? ¿Ha tenido enfermedades serias, o heridas serias?

(12)_____ Do you have any special concerns about this child's health or about the way he/she is growing or developing? Are there any things this child has difficulty doing compared to other children his/her age? ¿Tiene Vd algunas preocupaciones sobre la salud de este nino/a. o sobre su crecimiento o desarrollo? ¿Hay algo que su nino/a tenga mas dificultad para hacer comparadoa con otras ninos de su edad?

_____

_____

(13) _____ _____

Signature of person completing this form Date

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HEALTH DATA ENTRY FORM
PART II

Reporter ID: _____ Student No.: _____ Grade: _____ Year 19: _____ - _____

Child's Name: _____ Date of Birth: _____

Immunizations (Evaluation + update unless attended school in Montana this year)

Enter date. Circle immunizations given during the summer program.

V04.01	Polio							
V04.1	Smallpox							
V04.2	Measles							
V04.3	Rubella							
V04.6	Mumps							
V04.8	Influenza							
V06.1	DPT							
V06.12	Td							
V06.4	MMR							

Initial IZ Status: Complete [ ]
Incomp [ ]
Prov Comp [ ]

Final IZ Status: Complete [ ]
Incomp [ ]
Prov Comp [ ]

Comments regarding immunization records: _____

Screening			Re-Screening					
			Date	A/N/U	Value	Date	A/N/U	Value	Final Outcome
V20.2		Health Exam (Pre)							
V70.5		Health Exam (School)							
V70.5	90751	Health Exam (12-17 years)							
V70.5	90752	Health Exam (5-11 years)							
V20.2	90753	Health Exam (1-4 years)							
V20.2	90754	Health Exam (0-1 years)							
V72.0	90760	Vision			R L			R L	
V72.1	90760	Hearing			R L			R L	
V72.2	D0120	Dental							
V72.80	90760	Height							
V72,81	90760	Weight							
V74.1	86580	PPD (TINE)							
V78.0	85014	HCT							
V78.0	85018	Hemoglobin							
V81.1	90760	BP							
V82.81	90760	Scoliosis							

Dental Services

V72.2 D1120 Dental Prophy:_____(date)
V72.2 D1230 Dental Fluoride:_____(date) Partially Completed:_____(date)

Comments:_____
V72.2 D1350 Dental Sealants Completed:_____(date) Partially Completed: _____(date)

Comments:_____
Dental Treatment Completed: _____(date) Partially Completed: _____(date)

Comments:_____

Significant Active Problems: If an abnormal screening was noted on the SCREENING section, do not repeat it here.

Date	Diagnosis	ICD-9 Code	Type A/C	Status U/R	CPT Code	A/N/U	Plan/Outcome

Nurse's Signature:_____ Date Completed:_____